INTERNATIONAL FEDERATIONOF HEALTH AND HUMAN RIGHTS ORGANISATIONS/ EDHUCASALUD CONFERENCE 2006

INAUGURAL ADDRESS[1]

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I am always especially pleased to attend IFHHRO's conferences, not only because I learn a lot from them, but also because they provide me with an opportunity to briefly outline some of my more recent work and take questions and comments during our meetings – in other words, the conference provides a sort of informal accountability to civil society.

So this evening I begin with a brief sketch of some of my more recent activities. Then I make some observations about the health and human rights movement, followed by a few remarks about the critical role of health professionals.

Last month I presented to the UN my report on Uganda and neglected diseases.[2] These diseases, sometimes known as 'poverty-related' or 'tropical' diseases, include sleeping sickness, river blindness, and lymphatic filariasis. They inflict severe and permanent disabilities and deformities on almost 1 billion people around the world. They mainly affect the poorest people in the poorest communities.

In a way, the Ugandan report is not about Uganda, it is about all countries that suffer from neglected diseases. More than that, the report is about how to operationalise the right to health, how to make it real and practical. In this sense, the report has relevance beyond Uganda, and beyond neglected diseases, and I return to it later in these remarks.[3]

In January, I undertook a mission to Sweden. After Uganda, it felt like a mission to another planet. I wanted to look at one of the best health systems in the world. Also, I wanted to examine Sweden's international policies that bear upon the right to health in developing countries. Although Sweden's health system is formidable, when examined through the right to health lens, some flaws become clear. For example, while a couple of Swedish cities have introduced harm reduction projects (ie needle exchange programmes and so on), these are not available elsewhere in the country. Asylum seekers are discriminated against – they do not enjoy the same level of health care as others. For Sweden's indigenous people - the Sami – reindeer husbandry is a vital part of their culture. Obviously, herding reindeer in the mountains and forests

[1] This speech was delivered on the 11th October 2006 as the inaugural address for the conference "Exclusion and the Right to Health: The Role of Health Professionals", jointly organised by IFHHRO and EDHUCASALUD and held in Lima, Peru, 11 – 13 October 2006 (http://www.edhucasalud.org/ineq_e.htm).
[2] E/CN.4/2006/48/Add.2. Such reports can be most easily accessed at http://www2.essex.ac.uk/human_rights_centre/rth.shtm
[3] Neglected diseases mainly afflict neglected communities. It was the right to health analysis – and its preoccupation with disadvantage – that led to the identification of this neglected issue as a serious right to health problem demanding much greater attention.

miles from anywhere gives rise to distinctive work-related health hazards. Yet Sweden has no occupational health policy for Sami reindeer herders.

In short, at first sight, you might think that the right to health analysis has nothing useful to say to a country like Sweden. But I think the report shows this is not the case.

In March I completed a joint report on Guantanamo Bay.[4] The health content of the report focuses on the ethical responsibilities of health professionals in relation to the interrogation and forced feeding of detainees. The report also looks at the damaging impact of the detention – in all its dimensions - on the mental health of detainees in Guantanamo. The report calls for the forced feeding of competent detainees to cease; for detainees to be charged and tried before an independent tribunal, or otherwise to be released; and for Guantanamo to be closed.

In May I visited Australia where I discussed and promoted a substantive, detailed report prepared by the Social Justice Commissioner. This important report sets out a human rights based approach to Aboriginal health.[5]

In June, I publicly spoke against the sanctions imposed by donors on the Occupied Palestinian Territories. To their credit, for many years, donors funded the Palestinian health system. This year, following the election of a Hamas government in Gaza and the West Bank, these funds were withdrawn without first providing the Palestinians with an opportunity to make alternative financial arrangements. In other words, the donor community imposed humanitarian sanctions on sick, infirm and elderly Palestinians who were already deeply dependent and disadvantaged. These sanctions caused – and continue to cause - immense additional hardship and they profoundly jeopardise Palestinians' right to the highest attainable standard of health. This is contrary to the donors' responsibility of international assistance and cooperation in health.

In September, I presented a report to the Human Rights Council that sets out a methodology for measuring and monitoring the progressive realisation of the right to the highest attainable standard of health.[6] In brief, the right to health is subject to progressive realisation. This means that what is expected of a government varies over time. Therefore, we need a way of measuring and monitoring progressive realisation so that governments know whether or not their policies are actually delivering their right to health commitments. Building on the work of innumerable experts and consultations, the report sets out how indicators and benchmarks can measure and monitor the progressive realisation of the various dimensions of the right to the highest attainable standard of health. Of course, the methodology is not perfect, it will certainly need more work in the light of experience. But at least there is now a workable methodology for capturing progressive realisation, one of the critical and inescapable features of the right to health.

[4] E/CN.4/2006/120.
[5] Aboriginal and Torres Strait Islander Social Justice Commissioner, *Social Justice Report: 2005*, available at http://www.hreoc.gov.au.
[6] E/CN.4/2006/48.

Last month I visited Lebanon and northern Israel to assess the impact of the recent conflict on the right to health and to make recommendations. The mission was joint, I worked with three other UN independent experts each with their own human rights mandate.[7] In Lebanon, 12 health facilities were destroyed and 38 seriously damaged. Ambulances were hit and Lebanese Red Cross workers killed and injured. Today, hundreds of thousands of cluster bombs continue to kill and maim in south Lebanon. During the war, about one third of Israel was largely evacuated and four hospitals were damaged. Here, I cannot describe the destruction and suffering, but I want to emphasise that, in both countries, the poor and disadvantaged were hit hardest by the conflict. In our report we conclude that both Israel and Hezbollah were guilty of serious violations of international law. Last week, we presented our joint report to the Human Rights Council. I have to say that it was heavily criticised by many States – Arab, Israeli and the USA.

This is nothing like a comprehensive account of what I have been trying to do in the last twelve months or so. For example, I have not mentioned some very fruitful collaboration with the British Medical Association. Nor have I mentioned the December launch of a Leaders' Call to Action on the right to health that was signed by a number of luminaries from Jimmy Carter and Bill Clinton to Fernando Cardoso (former President of Brazil) and Ernesto Zedillo (former President of Mexico). This initiative depended very heavily on Realizing Rights: Ethical Globalisation Initiative, the non-governmental organisation headed by Mary Robinson.

Can I say that my work depends entirely on an extensive network of collaborators – some are in this room - who provide indispensable support and advice. Also, none of my work would be accomplished without the dedicated support of a very small team of very hardworking colleagues in Geneva and Essex University. I am extremely grateful to you all.

I would like to make some brief remarks about the movement for economic, social and cultural rights. Not only are the remarks brief, they are also very subjective. No doubt others will have other views.

Elsewhere I have argued that there is a trend to take economic, social and cultural rights more seriously than ever before.[8] I see evidence of this trend at the international, regional, national and community levels – in laws, policies, programmes and projects – within international organisations, governments and civil society. Frankly, I am often inspired by domestic civil society's fluency and familiarity with economic, social and cultural rights, not least here in Peru. Significantly, venerable international human rights organisations, like Amnesty International, which have historically focussed on civil and political rights, have recently added elements of economic, social and cultural rights to their agendas. In July, Amnesty published a study on maternal and infant health in Peru. Not long ago it was inconceivable that Amnesty might publish a report that rests upon a detailed analysis of the right to the highest attainable standard of health.[9]

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[7] A/HRC/2/7.

[8] Paul Hunt, "Taking Economic, Social and Cultural Rights Seriously", *Alternative Law Journal*, Vol 31:3, September 2006, pp-120-121.

[9] *Peru: poor and excluded women – denial of the right to maternal and child health*, AMR 46/004/2006.

Of course, the trend to take economic, social and cultural rights more seriously is contested, uneven and limited. But, in my view, the trend is unmistakeable: economic, social and cultural rights are on a rising tide.

There is some progress in another sense, too. The right to health is one of the most complex and extensive human rights in the international code. Before 2000, it was mentioned in a number of international treaties and national constitutions. Back then, it generated some case law and ground breaking academic literature. Also, some enterprising civil society groups were focussing on the right to health before 2000. Nonetheless, at that time, there was little agreement about the contours and content of the right to health – there was little detailed agreement about what the right actually means.

In 2000, that began to change. UN human rights treaty bodies adopted documents that set out what, in their view, the right to health means.[10] Of course, these documents leave many questions unanswered. While these documents are authoritative, they are not definitive. They are detailed, but not complete. They are legal, but not programmatic or operational. Nonetheless, as never before, they provide important guidance on the contours and content of the right to the highest attainable standard of health.

Since then many others – States, WHO, civil society, academics - have built on these foundations. Drawing on this inspirational work, my reports have sought to develop a way of 'unpacking' the right to health so it is more manageable, easier to grasp. I have applied this approach to specific elements of the right to health. The most detailed application of this approach is in my report on mental disabilities.[11] Here you will find a 'map' to the right to health that is not confined to mental disabilities. It has general application.

Of course we have to clarify, legally and conceptually, what the right to health means – but a much greater and more important challenge is to figure out how the right can be operationalised, how it can be put into practice.

You might recall the cliché – 'the devil is in the detail'. I have come to the view that in relation to economic, social and cultural rights, such as the right to health, the devil is *not* in the detail, but just the opposite. The devil is in excessively broad generalisations.

We have come just about as far as we can while addressing economic, social and cultural rights at an abstract, general level. If we are to take the next steps in the evolution of these rights, we have to build upon the legal and conceptual progress collectively made in recent years and apply those insights to specific issues in specific countries and specific contexts. This, it seems to me, is one of the lessons to be learnt from the pioneering work on human rights and HIV/AIDS.

[10] For example, CESCR's General Comment 14.
[11] E/CN.4/2005/51.

Of course, it is very challenging to operationalise the right to health in specific contexts, but we are more likely to make progress in this way than if we confine ourselves to sweeping generalisations of a large and abstract nature.

May I give an example? Earlier in these remarks I mentioned my UN report on Uganda and neglected diseases – sleeping sickness, river blindness, lymphatic filariasis and so on.

Examining Uganda's neglected diseases through the lens of the right to health underlines the importance of a number of policy responses.

First, it underscores the imperative of developing an *integrated* health system responsive to local priorities. Vertical interventions that focus on one particular disease can actually weaken the broader health system. While there might be a place for some vertical interventions, they must be designed, so far as possible, to strengthen, not undermine, an integrated health system.

Second, village health teams are urgently needed to identify local health priorities. Their local knowledge about the prevalence of disease in the community will enhance the perspectives provided by a health official from the regional or national capital.

Third, of course more health professionals are essential, but also incentives are needed to ensure that the health workers are willing to serve these remote neglected communities.

Fourth, there are myths and misconceptions about the causes of neglected diseases: these can be dispelled by accessible public information campaigns.

Fifth, some of those suffering from neglected diseases are stigmatised and discriminated against: this, too, can be tackled by evidence-based information and education.

Sixth, the international community and pharmaceutical companies also have responsibilities to provide needs-based research and development on neglected diseases, as well as other assistance.

Seventh, effective monitoring and accountability devices must be established. Existing parliamentary and judicial accountability mechanisms are not enough in relation to those diseases mainly affecting the most disadvantaged. In my report I suggest a way of enhancing accountability in relation to neglected diseases in Uganda.

My main point is that the right to health has something precise, practical, constructive and operational to contribute to serious, complex, specific health issues. Of course, the right to health does not bring a magic solution. Also, it is true that you could identify these policy responses to neglected diseases without reference to the right to the highest attainable standard of health. But the right to health can help to identify these responses and, where they already exist, the right can reinforce them.

Because of its evolution in recent years, the right to health – as never before - is in a position to shape national and international policy-making. If integrated into policy-

making, the right can help to establish policies that are robust, sustainable, equitable, and meaningful to those living in poverty.

But here we come to a very major challenge.

There is no chance of operationalising the right to health without the active engagement of many health professionals. Effectively, health professionals run the key international health organisations, as well as Ministries of Health across the globe. Naturally, they dominate the health sector, both public and private. We have no chance of putting the right to health into practice without large numbers of well-positioned health professionals understanding and supporting this endeavour.

The progress that has been made in recent years could not have been made without the active support of health professionals who are working at the international, national and community levels. My Ugandan report depended upon expert advice from health professionals in WHO and the Ugandan Ministry of Health. My report on Peru in 2004 depended on the active support of health professionals at the highest levels of government and within PAHO.

But I will be frank.

Most health professionals in most Ministries of Health have not even heard of the right to the highest attainable standard of health. If they have heard of it, they have no idea what it means, neither conceptually nor operationally. If they have heard of it, they are probably worried that it is something that will get them into trouble. They do not understand that the right to health is an asset that they can use to devise good policies, enhance health systems, raise more funds from the Ministry of Finance, and improve their own terms and conditions of work. As for international organisations, for the most part, the right to health is not yet consistently applied throughout these bodies. Many health professionals working in these international bodies do not grasp that the right to the highest attainable standard of health can help them achieve their objectives.

Where health professionals have a sense of the right to health, it is often rhetorical. Rhetoric is important and valuable. But the right to health is much more than rhetoric. Grounded in national and international law, the right to health has a *practical* application that can save lives and reduce suffering, especially amongst the most vulnerable, disadvantaged and excluded.

The right to a fair trial would not have become so widely accepted and implemented without the active support of lawyers. Equally, the right to health will not animate health policies and systems without greater support from health professionals. This, it seems to me, is one of our greatest challenges: how to educate more health professionals about the practical utility of human rights. And this is why IFHHRO – and all its member organisations – is so extremely important.

Those of us committed to the right to health are engaging with international organisations, Ministries of Health, other health-related Ministries, the public and private health sectors, pharmaceutical companies, civil society and the public at large. Between us, we have developed the essential normative framework. We are beginning

to apply it in a practical, operational manner. Of course, there is much more to do – and we can do it, provided we can persuade more health professionals to play their part.

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